

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2016
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT STANDIFER PLACE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2626 WALKER RD CHATTANOOGA, TN 37421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments A licensure survey and complaint investigation #37402, #37522, #37694, #37788, #37809, #37883, #37893, #37997, #38010, #38383, #38413, #38572, #38774, #38843, and #38968 were completed on 6/20-23/2016 at The Health Center at Standifer Place. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6/09

OCY311

If continuation sheet 1 of 1